Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TARRANT COUNTY HOSPITAL DISTRICT
1400 S MAIN ST
FORT WORTH TX 76104-4909

Respondent Name
LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-09-0823-01

MFDR Date Received
September 30, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility contends that reimbursement at 15% of total charges is not fair and reasonable. Generally, outpatient claims processed on average were processed at approximately 50% of total charges and trauma charges were usually negotiated between 60 and 75% of total charges."

Amount in Dispute: $15,892.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The outpatient charges for services on 2/10/08 were processed at our fair and reasonable reimbursement. . . . In most cases the fair and reasonable rate is determined at 125% of Medicare. In the instance of the multiple radiology codes on this bill, we have used the technical component for the lesser of the facility or the OPPS Cap Facility rate. . . . Our position remains the same regarding reimbursement for services of 2/10/2008"

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 10, 2008	Outpatient Hospital Services	$15,892.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - B377 – THIS IS A BUNDLED PROCEDURE; NO SEPARATE PAYMENT ALLOWED. (B377)
   - B398 – THIS PROCEDURE IS INCLUDED IN THE PRIMARY PROCEDURE. (B398)

- U454 – THIS OFFICE VISIT IS INCLUDED IN THE VALUE OF THE SURGERY OR ANESTHESIA PROCEDURE. IF A MINOR PROCEDURE PERFORMED AFTER EXAM AND DECISION MAKING. PLEASE SUBMIT SUPPORTING DOCUMENTATION. (U454)
- U490 – THE NON-COMPLETE RADIOLOGY, CONTRAST MATERIAL AND/OR REPORT IS INCLUDED IN THE COMPLETE RADIOLOGY PROCEDURE. (U490)
- Z125 – NON-MEDICAL MANAGEMENT SERVICES. PAYMENT ALLOWED. (Z125)
- Z345 – LEFT SIDE. (Z345)
- Z585 – THE CHARGE FOR THIS PROCEDURE EXCEEDS FAIR AND REASONABLE. (Z585)
- Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
- Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)

Findings

1. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(c)(2)(C), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division." Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed health care and charges in the form and manner prescribed by the Division. The requestor did not indicate an amount in dispute in the indicated column. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C). The Division will deem the amount in dispute to be $15,892.40 for the purpose of this review.
4. Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include a position statement of the disputed issue(s) including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
5. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor's position statement asserts that "Our facility contends that reimbursement at 15% of total charges is not fair and reasonable. Generally, outpatient claims processed on average were processed at approximately 50% of total charges and trauma charges were usually negotiated between 60 and 75% of total charges."
   - The requestor did not submit documentation to support that 15% of total charges is not fair and reasonable.
   - The requestor did not submit documentation to support that outpatient claims on average were processed at approximately 50% of total charges or that trauma charges were usually negotiated between 60 and 75% of total charges.
   - The requestor does not discuss or explain how the average amounts paid or negotiated for other claims supports the requestor's position that the amount sought in this dispute is a fair and reasonable reimbursement for the disputed services.

- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  > A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.